MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08747

CERTIFICATE OF DEATH

Reg. Dist. No. 51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Calvert, MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prince Frederick; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland, COUNTY Calvert; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owensville; STREET ADDRESS (If rural, give location) Prince Fred. Md.

3. NAME OF DECEASED (Type or Print): (First) Sadie (Middle) Sarah (Last) Bean

4. DATE OF DEATH: (Month) 9 (Day) 14 (Year) 1951

5. SEX: F

6. COLOR OR RACE: C.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Feb 20 1900

9. AGE last birthday: 51 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Calvert Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Phillips

14. MOTHER'S MAIDEN NAME: Mary F. Boome.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-09-6567

17. INFORMANT AND ADDRESS: Ella Banister Owensville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chr myocarditis

422.2 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93d (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1951, to 9/13, 1951, that I last saw the deceased alive on 9/14, 1951, and that death occurred at 5 A.M., from the causes and on the date stated above.

SIGNATURE H Owens (Degree or title) MD ADDRESS Hewitts town Md DATE SIGNED 9/14/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 9-16-51

NAME OF CEMETERY OR CREMATORY St Johns

LOCATION (City, town, or county) Luby, Ark. (State) Md

DATE REC'D BY LOCAL REG. 9-15-51

REGISTRAR'S SIGNATURE N. H. Ward

24. FUNERAL DIRECTOR R. E. Sewell. ADDRESS

RECEIVED
SEP 19 1951
BUREAU V. S.

08748

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 51

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ocean Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Capitol Heights
STREET ADDRESS (If rural, give location) 103-63 Place

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Edward (Last) Good
4. DATE OF DEATH (Month) 9 (Day) 4 (Year) 1951
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH Nov 15 1869
9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R R Retired
10b. KIND OF BUSINESS OR INDUSTRY R R
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Good
14. MOTHER'S MAIDEN NAME Emma Minnick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Louise Payne 103-61 Place Capitol

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 6 mos

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Age

Died 4. P.M.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dropped dead when he moved to bed

19a. DATE OF OPERATION Firm Chair
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H Howard (Degree or title) ADDRESS Fairview DATE SIGNED Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/7/51
NAME OF CEMETERY OR CREMATORY Cedar Hill MC
LOCATION (City, town, or county) Anacostia (State)
DATE REC'D BY LOCAL REG. 9/4/51
REGISTRAR'S SIGNATURE H Howard
24. FUNERAL DIRECTOR Chamber Wash ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

VVV 506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08749

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH: COUNTY CALVERT MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SOLOMONS
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Solomons
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Jack (Last) Johnston
4. DATE OF DEATH (Month) 9 (Day) 12 (Year) 1951

5. SEX Mald
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Nov. 24 - 1880
9. AGE last birthday 70 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pa. State Road -
10b. KIND OF BUSINESS OR INDUSTRY Hauling
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Johnston -
14. MOTHER'S MAIDEN NAME (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no - (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 198-18-2259
17. INFORMANT AND ADDRESS John H - Miller -

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 11 hr.

Antecedent cause(s) 420.1 94a (b) Cardiac Degeneration — 4 yr.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ✓

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ✓

19a. DATE OF OPERATION ✓
19b. MAJOR FINDINGS OF OPERATION ✓
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE ✓ (Specify) ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from ....., 19....., to Sept. 12, 1951, that I last saw the deceased alive on Sept 6, 1951, and that death occurred at 11 A. m., from the causes and on the date stated above.

SIGNATURE E. S. Coster - (Degree or title) M.D. - ADDRESS Solomons - Md. DATE SIGNED 9/12/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 14-51
NAME OF CEMETERY OR CREMATORY Methodist -
LOCATION (City, town, or county) (State) Solomons, Md.

DATE REC'D BY LOCAL REG. 9/12/51
REGISTRAR'S SIGNATURE N. E. S. Coster
24. FUNERAL DIRECTOR A. A. Harkness & Son - ADDRESS Mutual Md.

683 246

MARGIN RESERVED FOR BINDING

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VS. A15

RECEIVED
SEP 20 1951
BUREAU V. S.